Stony Brook Medicine

HERNIA CENTER HEALTH HISTORY QUESTIONNAIRE

Please complete this questionnaire in full. This information will assist us in your care plan. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

For patients living at a distance, this questionnaire is designed to help facilitate your examination, admission, and surgery in one visit. However, an in-person physical examination at our clinic is required to make a final diagnosis and a treatment plan.

Please fax a completed copy to 631-638-0050.

Name *(Last, First, M.I.):*	
DOB:	
☐ M ☐ F	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Islander/Hawaiian ☐ Other_____	
Address:	**City, State, Zip:**
Home Phone:	**Cell/Work Phone:**
Email:	**Language:**
Referring doctor:	**Date of last physical exam:**
Emergency Contact:	**Emergency Contact Phone:**
Occupation/Retired:	**Employer:**
Business Address:	**Business Phone Number:**
How did you hear about us? ☐ Medical Doctor:_____ ☐ Friend ☐ Article ☐ Website:_____ ☐ Other:_____	

Surgeon Requested:

☐ Andrew Bates	☐ Salvatore Docimo	☐ Polikseni Eksarko	☐ Jill Genua
☐ Kathreen Lee	☐ Michael Paccione	☐ Aurora Pryor	☐ Jerry Rubano
☐ Daniel Rutigliano	☐ Samer Sbayi	☐ Jessica Schnur	☐ Marc Shapiro
☐ Konstantinos Spaniolas	☐ James Vosswinkel		

HEALTH INSURANCE INFORMATION		
Insurance Carrier:		**Insurance ID:**
Primary Insured:	**DOB:**	**Primary Insured Relationship:**
Secondary Insurance Carrier:		**Secondary Insurance ID:**
Primary Insured:	**DOB:**	**Primary Insured Relationship:**

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PERSONAL HEALTH HISTORY

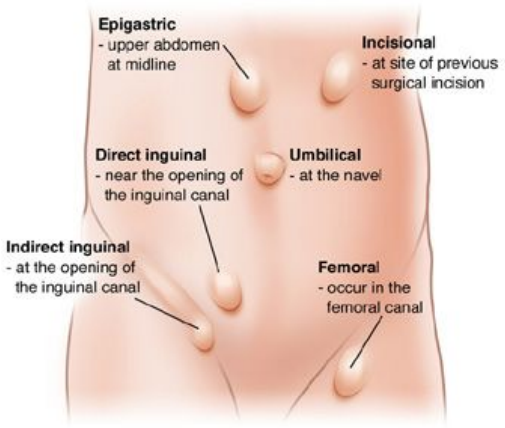
Height:	Weight	BMI	Recent Weight Gain or Loss:
Waist at the navel (inches):			Chest, not expanded (inches):

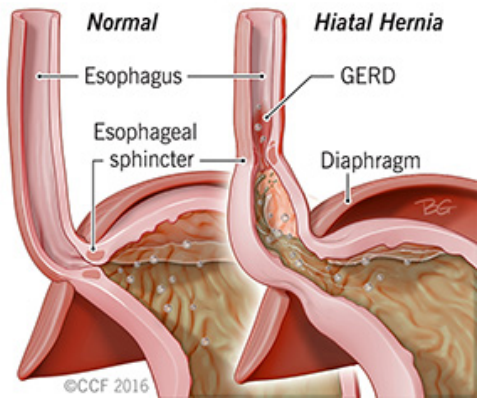
Have you had hernia surgery before: ☐ Yes ☐ No **If so, which type?**

Have you had a medical evaluation of your suspected hernia confirming a hernia present: ☐ Yes ☐ No **Hernia Type:**

Are you inquiring about a Shouldice repair for your inguinal, umbilical, ventral or incisional hernia? ☐ Yes ☐ No

Hernias that you want repaired:





PLEASE CHECK:

☐ Epigastric Hernia
☐ Femoral Hernia
☐ Incisional Hernia
☐ Inguinal Hernia: Right or Left
☐ Paraesophageal/Hiatal Hernia
☐ Spigelian Hernia
☐ Umbilical Hernia
☐ Ventral Hernia

RIGHT Inguinal or Femoral	**LEFT Inguinal or Femoral:**
Is this your first RIGHT groin hernia? ☐ Yes ☐ No	Is this your first LEFT groin hernia? ☐ Yes ☐ No
Previous repairs? ☐ Yes ☐ No Date of last repair:	Previous repairs? ☐ Yes ☐ No Date of last repair:
Can you reduce (push back in) your hernia? ☐ Yes ☐ No	Can you reduce (push back in) your hernia? ☐ Yes ☐ No
Size of hernia: ☐ No Noticeable bulge ☐ Walnut ☐ Egg ☐ Grapefruit	Size of hernia: ☐ No Noticeable bulge ☐ Walnut ☐ Egg ☐ Grapefruit
Umbilical, Epigastric, Spigelian, or Ventral Hernia:	**Para-esophageal, Hiatal, or Diaphragmatic Hernia:**
Is this your first hernia of this type? ☐ Yes ☐ No	Is this your first hernia of this type? ☐ Yes ☐ No
Previous repairs? ☐ Yes ☐ No Date of last repair:	Previous repairs? ☐ Yes ☐ No Date of last repair:
Can you reduce (push back in) your hernia? ☐ Yes ☐ No	Can you reduce (push back in) your hernia? ☐ Yes ☐ No
Size of hernia: ☐ No Noticeable bulge ☐ Walnut ☐ Egg ☐ Grapefruit	Are you experiencing reflux: ☐ No ☐ Mild ☐ Moderate ☐ Severe
For incisional hernia, what was the original operation?	Do you experience: ☐ Nausea ☐ Vomiting ☐ Aspiration ☐ Chest Pain

Additional Information About Your Hernia(s):

Has the hernia(s) identified above been diagnosed by a medical doctor? ☐ Yes ☐ No

If so, how? ☐ Physical Exam ☐ Ultrasound ☐ Other:

Are you experiencing chronic pain from a previous hernia repair? ☐ Yes ☐ No

Have you experienced a wound infection in any previous surgery? ☐ Yes ☐ No

Did you have mesh placed during a previous hernia surgery? ☐ Yes ☐ No

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Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital
Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken
Do you take buprenorphine ,suboxone ,naltrexone or similar?		
Allergies to medications		
Name the Drug	Reaction You Had	

Have you ever had, past or present?	Yes / No / Other	Details to all questions answered yes
Abnormal reaction to local or general anesthetic or history of malignant hyperthermia?	☐ Yes ☐ No ☐ Other	
A family member that has had an abnormal reaction to anesthetic?	☐ Yes ☐ No ☐ Other	
Heart trouble, heart attack, angina, mechanical valves, or irregular heartbeat?	☐ Yes ☐ No ☐ Other	
A history of blocked artery in the heart, heart failure, Ischemic heart disease?	☐ Yes ☐ No ☐ Other	
A History of chest pain while performing activities, or while resting?	☐ Yes ☐ No ☐ Other	

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Have you ever had, past or present?	Yes / No / Other	Details to all questions answered yes
Autoimmune disease (chronic inflammatory state)?	☐ Yes ☐ No ☐ Other	
Active hepatitis or a history of liver disease?	☐ Yes ☐ No ☐ Other	
A history of peripheral arterial disease (poor blood flow to the legs)?	☐ Yes ☐ No ☐ Other	
Abnormal blood pressure, high or low, or pulmonary hypertension?	☐ Yes ☐ No ☐ Other	
Medicine for your heart or high blood pressure?	☐ Yes ☐ No ☐ Other	
Difficulty with breathing or had unusual tiredness or weakness?	☐ Yes ☐ No ☐ Other	
Pacemaker or defibrillator implanted?	☐ Yes ☐ No ☐ Other	
Do you have any other implanted devices?	☐ Yes ☐ No ☐ Other	
Lung illness, asthma, emphysema, chronic bronchitis, or tuberculosis?	☐ Yes ☐ No ☐ Other	
Chronic Obstructive Pulmonary Disease (COPD)?	☐ Yes ☐ No ☐ Other	
Severe snoring?	☐ Yes ☐ No ☐ Other	
Sleep apnea or do you sleep with a breathing machine?	☐ Yes ☐ No ☐ Other	
Difficult laryngoscopy or narrowing of windpipe?	☐ Yes ☐ No ☐ Other	
Difficult intubation?	☐ Yes ☐ No ☐ Other	
Shortness of breath?	☐ Yes ☐ No ☐ Other	
Medicine for asthma or other lung illness?	☐ Yes ☐ No ☐ Other	
Lightheaded when you get up, even when not standing abruptly?	☐ Yes ☐ No ☐ Other	
Scoliosis?	☐ Yes ☐ No ☐ Other	
Kidney illness or problems with urination?	☐ Yes ☐ No ☐ Other	
Frequent urination?	☐ Yes ☐ No ☐ Other	
History of end stage renal disease?	☐ Yes ☐ No ☐ Other	

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Does any family member have easy bruising or unusual bleeding?	☐ Yes ☐ No ☐ Other	
Severe or unusual bleeding following any trauma, cut or dental extraction?	☐ Yes ☐ No ☐ Other	
A blood disorder (high or low platelets, hemoglobin or white cells)?	☐ Yes ☐ No ☐ Other	
Blood clots in the legs, (DVT) or in the lungs (pulmonary embolism)?	☐ Yes ☐ No ☐ Other	
Diabetes or abnormal blood sugar?	☐ Yes ☐ No ☐ Other	
Frequent urination, blurred vision, and strong thirst?	☐ Yes ☐ No ☐ Other	
Problems with digestion, bowel function, bleeding or vomiting?	☐ Yes ☐ No ☐ Other	
Jaundice, hepatitis, cirrhosis, or ascites (fluid in the abdomen)? When? Type?	☐ Yes ☐ No ☐ Other	
A sexually transmitted disease or been exposed to/tested positive for HIV?	☐ Yes ☐ No ☐ Other	
Steroids, prednisone, cortisone, ACTH or related medicines?	☐ Yes ☐ No ☐ Other	
A stroke, unusual dizziness, blackouts, tremors, or memory loss?	☐ Yes ☐ No ☐ Other	
Do you have any neurological disorders (e.g. Parkinson's, Epilepsy, Dementia)?	☐ Yes ☐ No ☐ Other	
Do you have any neuromuscular disorders (e.g. Myasthenia gravis, multiple sclerosis)?	☐ Yes ☐ No ☐ Other	
Do you have any arthritis, lupus or rheumatological disease?	☐ Yes ☐ No ☐ Other	
Do you have any loose teeth, capped teeth, or false teeth?	☐ Yes ☐ No ☐ Other	
Do you have problems with eyesight or wear contact lenses?	☐ Yes ☐ No ☐ Other	
Do you smoke or use tobacco or electronic cigarettes? How much per day?	☐ Yes ☐ No ☐ Other	
Do you cough or have sputum from smoking?	☐ Yes ☐ No ☐ Other	
Do you use street or recreational drugs or are you on a drug maintenance program?	☐ Yes ☐ No ☐ Other	
Do you drink alcohol? How often and how many drinks per week?	☐ Yes ☐ No ☐ Other	
Do you have cultural or religious practices or requirements that we should know of?	☐ Yes ☐ No ☐ Other	
Do you have any special needs or require supervision or attendant care (e.g. Vision, mobility, dietary, disability)?	☐ Yes ☐ No ☐ Other	

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Do you live alone, in a retirement home or nursing home?	☐ Yes ☐ No ☐ Other	
Are you allergic to anything (e.g. medication, food, environmental, latex)?	☐ Yes ☐ No ☐ Other	
Were you hospitalized in the past 6 months for anything?	☐ Yes ☐ No ☐ Other	
Are you pregnant or within 12 months of the end of a pregnancy?	☐ Yes ☐ No ☐ Other	
Have you undergone chemotherapy in the past 12 months?	☐ Yes ☐ No ☐ Other	
Have you undergone radiation therapy near your hernia in the past 12 months?	☐ Yes ☐ No ☐ Other	
Have you ever had cancer, chemotherapy or radiation?	☐ Yes ☐ No ☐ Other	
Can you climb two flights of stairs without shortness of breath?	☐ Yes ☐ No ☐ Other	
Have you ever been diagnosed with MRSA?	☐ Yes ☐ No ☐ Other	
Do you take herbal medications? If so, which ones?	☐ Yes ☐ No ☐ Other	
Have difficulty taking care of yourself?	☐ Yes ☐ No ☐ Other	
Have difficulty doing housework like vacuuming, or moderate recreational activities like golf or dancing?	☐ Yes ☐ No ☐ Other	
How do you rate your health right now?	☐ Good ☐ Fair ☐ Poor	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					

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	Are you concerned about the amount you drink?		☐ Yes	☐ No
	Have you considered stopping?		☐ Yes	☐ No
	Have you ever experienced blackouts?		☐ Yes	☐ No
	Are you prone to "binge" drinking?		☐ Yes	☐ No
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day_____	☐ Chew - #/day____	☐ Pipe - #/day_____	☐ Cigars - #/day _____
	☐ # of years_____	☐ Or year quit_____		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Sex	Are you sexually active?		☐ Yes	☐ No
	If yes, are you trying for a pregnancy?		☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?		☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		☐ Yes	☐ No
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?		☐ Yes	☐ No
	Would you like information on the preparation of these?		☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

Family Member	AGE	SIGNIFICANT HEALTH PROBLEMS	Family Member	AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Do you suffer from depression, anxiety schizophrenia, ADHD, OCD or any other psychiatric condition?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No

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Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies: _____ Number of live births: _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

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☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please list any doctors you see:

Name_____ Specialty_____ Phone Number_____

Name_____ Specialty_____ Phone Number_____

Name_____ Specialty_____ Phone Number_____

Name_____ Specialty_____ Phone Number_____

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The Shouldice repair has demonstrated continued success for over 70 years as practiced at Shouldice Hospital in Canada, ***if the patient has acceptable weight for their height***. Weight is a very important factor. If the patient's body frame is large, we can relax on the increased weight, but if it is small, then weight becomes a problem.

Small body frame in and of itself isn't an issue for the repair, but is looked at when examining a patient's weight. Hence, small body frame and not overweight is encouraging, but small body frame and overweight needs to have weight loss. Large body frame better distributes the body weight because of the larger frame, but weight is still strongly considered during the discussion.

Overweight poses a potential risk for recurrence, bleeding, infection, and chronic pain. The following table used at Shouldice Hospital (founded by Dr. Shouldice) shows ideal weights for height and body frame size:

Men's Body Frame Size				Women's Body Frame Size			
Height	*Small*	*Medium*	*Large*	*Height*	*Small*	*Medium*	*Large*
5'6"	158 lb	167 lb	182 lb	4'10"	125 lb	136 lb	147 lb
5'7"	161 lb	170 lb	186 lb	4'11"	128 lb	139 lb	150 lb
5'8"	164 lb	173 lb	190 lb	5'0"	131 lb	142 lb	153 lb
5'9"	167 lb	176 lb	194 lb	5'1"	134 lb	145 lb	157 lb
5'10"	170 lb	180 lb	198 lb	5'2"	137 lb	148 lb	161 lb
5'11"	174 lb	184 lb	202 lb	5'3"	140 lb	151 lb	165 lb
6'0"	178 lb	188 lb	207 lb	5'4"	143 lb	154 lb	169 lb
6'1"	182 lb	192 lb	212 lb	5'5"	146 lb	157 lb	173 lb
6'2"	186 lb	197 lb	217 lb	5'6"	149 lb	160 lb	177 lb
6'3"	190 lb	201 lb	221 lb	5'7"	152 lb	163 lb	180 lb
6'4"	194 lb	205 lb	225 lb	5'8"	155 lb	166 lb	183 lb
6'5"	198 lb	209 lb	229 lb	5'9"	158 lb	169 lb	186 lb
6'6"	204 lb	221 lb	233 lb	5'10"	161 lb	172 lb	189 lb

Verification of information:

By signing below, you acknowledge that the information given in this packet is accurate to the best of your knowledge.

_____

CLIENT'S NAME (Please print)

_____ _____

SIGNATURE OF CLIENT OR SIGNATURE OF GUARDIAN TO CLIENT DATE

PERMISSION TO EXCHANGE INFORMATION:

I, _____ HEREBY GRANT PERMISSION FOR COMMUNICATION BETWEEN THE PROFESSIONAL STAFF OF The STONY BROOK MEDICINE HERNIA CENTER, REGARDING ANY AND ALL OF MY PSYCHOLOGICAL, MEDICAL, PSYCHIATRIC, RADIOLOGICAL, EDUCATIONAL AND SOCIAL RECORDS AS RELATED TO MY ENGAGEMENT IN THE HERNIA CENTER'S PROGRAMS AND/OR HERNIA SURGERY INTERVENTIONS.

_____

CLIENT'S NAME (Please print)

_____ _____

SIGNATURE OF CLIENT OR SIGNATURE OF GUARDIAN TO CLIENT DATE

In addition, I also grant permission for exchange of information with:

_____

_____

_____

(Indicate name; include address and phone if possible)